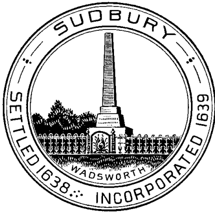

Town of Sudbury
Board of Health

DPW Office Building
275 Old Lancaster Road
Sudbury, MA 01776
978 440-5479

Calendar Year 2020

TO: Sudbury Trash Haulers'

RE: 2020 Trash Hauler Permit Renewal

Our records indicate it is time to renew your current Trash Hauler's Permit that will expire December 31, 2019. Please read through the instructions and fill out the enclosed forms. The Sudbury Department of Health will require submission of the following forms and applications in order to issue a 2020 Trash Hauler's Permit;

- Sudbury Application $100.00 New, $75.00 Renewal & $75.00 per truck. Please Indicate all trucks that will be doing pick up in the town. (ex. $75.00 Renewal + 4 trucks X $75.00 = $375.00).
- Application Fee (checks payable to the Town of Sudbury)
- Worker's Compensation Insurance Affidavit (enclosed)
- Copy of your Workers Compensation Insurance Declaration page.

If you have any questions or concerns, please do not hesitate to contact us at 978-440-5479.

Thank you for your attention to this matter.

Sincerely,

Bill Murphy

Sudbury Health
Sudbury Board of Health
health@sudbury.ma.us
Monday-Friday
8:00am-3:00pm
978-440-5479

SUDBURY BOARD OF HEALTH
2020 APPLICATION FOR TRASH HAULER'S PERMIT

Renewal = $75.00

New Hauler = $100.00 & Per Truck = $75.00

Payable To: Town of Sudbury

275 OLD LANCASTER RD.

SUDBURY, MA. 01776

____

Social Security # or Voluntary Federal Identification Number:

Your Social Security number, or FID number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Massachusetts General Law, Chapter 62C, Section 49A.

I hereby petition the Sudbury Board of Health to issue a Trash Hauler 's Permit for the undersigned to engage in the practice of collecting residential and commercial trash in the Town of Sudbury for the calendar year 2019.

I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes as required under law.

____

FULL NAME / ADDRESS / PHONE / EMAIL OF PERSON, FIRM, OR CORPORATION

____

FULL NAME AND CONTACT INFORMATION FOR EMERGENCIES.

MAKE OF VEHICLE	YEAR	CAPACITY	STATE	REGISTRATION NUMBER

____

NAME OF APPLICANT **DATE OF APPLICATION**

OFFICE USE ONLY

DATE APPROVED: ____________________ AMT PAID: __________________________

PERMIT NUMBER: ____________________ CHECK #:____________________________

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.
TO BE FILED WITH THE PERMITTING AUTHORITY.

Applicant Information **Please Print Legibly**

Business/Organization Name:____________________

Address:____________________

City/State/Zip:____________________ Phone #:____________________

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _________ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other ____________________

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name:____________________

Insurer's Address:____________________

City/State/Zip: ____________________

Policy # or Self-ins. Lic. #____________________ Expiration Date:____________________

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature:____________________ Date:____________________

Phone #:____________________

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: ____________________ **Permit/License #**____________________

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other ____________________

Contact Person:____________________ **Phone #:**____________________